Mamela

Médecins Sans Frontières / Doctors Without Borders South Africa
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SOLIDARITY FOR SURVIVAL
MIGRANTS & HEALTHCARE

MALARIA
MASSIVE RISE IN DRC

SAHEL REGION
NUTRITION CRISIS

RECRUITS ON MISSION
NURSING IN NIGER & AFGHANISTAN

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Ethiopia © Samuel Hauenstein Swan

WHAT YOUR SUPPORT DID IN 2011

Each year, MSF produces an annual International Activity Report which details our global operations. It's vital that we show the public, and our donors, where their money goes and what it does. Here is a selection of facts and figures from our 2011 report.

Outpatient consultations	8,407,596
Admitted patients	446,197
Malaria: total number of cases treated	1,422,839
Severely malnourished children admitted to inpatient feeding programmes	67,956
HIV patients registered under care at the end of 2011	228,750
Women who delivered babies, including caesarean sections	191,960
Medical and surgical interventions in response to direct violence	54,297
Patients medically treated for sexual violence	14,911
New admissions to tuberculosis first-line treatment	30,707
People vaccinated against measles in reponse to an outbreak	5,034,546
Relief kits distributed	225,550
Antenatal consultations	821,812
Litres of water distributed	96,058,426

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SOUTH AFRICA, THE PROMISED LAND?

Migration and displacement mean medical needs are ignored, but MSF pushes through to show solidarity for survival

To me, migration has always been a fascinating phenomenon. Even though the deeper motives behind why people leave their country of origin vary, there is always a common denominator – the quest for a better life.

However, in this latest edition of MAMELA you will not meet any westerners who move south to enjoy the sun and la dolce vita. Instead, you will meet people who are on the move to escape perpetual conflict, violence, hunger and other unliveable conditions in their home countries. This is the reality of over 40 million people around the world who have been forcibly displaced.

Each year, approximately 500,000 new asylum seekers arrive in South Africa – more than all 27 countries in Europe combined. Those who make the perilous journey from the Democratic Republic of Congo, Somalia and Zimbabwe along with many others, then face a daily struggle to access to basic services, harsh living conditions and an absence of healthcare.

These vulnerable people are marginalised, stigmatised and victimised – which worsens the public health risks they face because they are largely invisible and excluded from medical services. Their irregular legal status means they fear exposure and avoid the South African authorities, so they often don't openly seek healthcare at hospitals and clinics – placing themselves and others at greater risk. Today, the need for healthcare solutions to assist these people in distress and on the move is urgent.

In this issue, you will find an article on MSF South Africa's recently launched Solidarity for Survival campaign (pg 6) which seeks to raise awareness about the unrecognised health needs among people who are forced to flee their home countries for South Africa.

Other features in this edition also make the link between displacement, or mobility, and its impact on health: in West Africa's Sahel region (pg 10) a growing nutritional crisis has been worsened by conflict-related displacement in Mali and its neighbour states; a dramatic upsurge in malaria cases in eastern DRC (pg 4) is linked to people having to flee into malaria areas to avoid renewed fighting.

It's in situations like these which MSF medical workers witness firsthand. Nurse Sedi Mbelani (pg 13) has just returned from Niger where she worked to treat malnourished children with malaria. Sedi immigrated to South Africa from Congo-Brazzaville and has a keen interest in vaccination campaigns which MSF regularly undertakes during displacement emergencies.

Such vaccination campaigns are often done because vaccination coverage in under-developed states and in remote areas is particularly low (pg 9). Consider then also that South Africa is among the world's top 10 countries with the lowest vaccination rates. This, coupled with the inability of vulnerable migrants get unhindered healthcare in the South African health sector is cause for great concern.

For me, Sedi is an inspiration because she knows the dangers that discrimination brings to health, having seen the effects when she worked in displacement camps in Johannesburg during the xenophobic violence in 2008. Sedi keeps on reaching out to people in distress, whether they are in South Africa or in Niger – whether they suffer from malnutrition, violence or HIV – she keeps on showing true solidarity for their survival.

Best wishes,

Dan Sermand
General Director ad interim, MSF South Africa

Read MSF's report 'Nowhere Else To Go' about living conditions in Johannesburg slums: http://bit.ly/pWm7mZ

FIELD NEWS

Cleaning up Johannesburg inner-city slum buildings: MSF teams up with residents

MSF has been providing primary healthcare and medical screenings to Zimbabwean and other migrants and asylum seekers in Johannesburg since 2007. Many of them live in abandoned, or otherwise run-down buildings hijacked or controlled by slumlords who provide little or no maintenance. Inside these buildings, overcrowding, poor sanitation, water supply and inadequate waste management and disposal are a harsh reality impacting on residents' health.

To combat this MSF started working with residents in one slum building in December 2010 to actively clear it of years of waste and debris while improving how waste is handled. In April 2012, MSF approached residents of another building to repeat the process, providing support and cleaning materials and arranging for ongoing removal of the waste by the Johannesburg city municipal services. The clean up is done mostly by residents who clean at night after their day jobs – to ensure that the project remains sustainable.

This environmental focus heralds a new direction for the Johannesburg project. MSF teams will gradually halt medical screening activities as migrants increasingly gain access to the city's health facilities where they used to be turned away. At the same time MSF will keep negotiating for access to more slum buildings to do clean-up activities alongside residents.

MSF receives US$28 million grant for HIV research

In April 2012, MSF was awarded a grant of US$28 million from UNITAID, an international WHO-backed funding facility, towards a US$130 million*, three-year project investigating HIV testing in remote, resource-limited settings in 6 countries in Africa. This is the largest single donation that MSF has ever received for a specific research implementation project.

Effective testing for HIV is an essential but an under-invested part of treating the disease. Two tests in particular are vital for effective treatment:

- CD4 tests measure when HIV-positive people should start antiretroviral (ARV) medication. In South Africa, everyone with a CD4 count of below 350 is given ARVs.
- Viral load tests measure how well people are responding to ARV treatment. A high viral load suggests they may not be taking their treatment correctly, or that they need to switch to second-line drugs. Viral load tests are also essential to detect infection in babies of HIV-positive mothers.

"There is ongoing debate about the importance of these tests as they are both expensive and difficult to use in rural parts of Africa. This MSF project – which will be rolled out within eight existing projects in Lesotho, Malawi, Mozambique, South Africa, Swaziland and Uganda – aims to develop and study the reliability and feasibility of various CD4 and viral load tests in a variety of remote places," Dr. Tom Ellman, head of the South African Medical Unit explains.

The study will look at new approaches to testing in which testing is done at the 'point of care' closer to the patients' homes in rural areas, rather than only in specialised urban laboratories.

In this way, MSF intends to show that these tests are not only vital, but can be made more effective and easier to use in rural places. This also corresponds to UNITAID's goal to improve the pricing of diagnostic tools by first demonstrating the need and promoting demand, which in turn increases overall access to more affordable testing.

*The remainder of this amount will consist of private funding.

CORPORATE DONATIONS:
HOW BUSINESSES CAN GIVE BACK

MSF is the ideal option for companies large and small who want to donate corporate gifts, or as part of their corporate social responsibility programmes. Ludivine Houdet, MSF South Africa's Corporate & Major Donor Coordinator, explains why.

As an internationally renowned medical humanitarian organisation with a number of innovative projects in South Africa, MSF is a great prospect for businesses to support local communities and touch lives while fulfilling their corporate social responsibility requirements.

MSF is a registered Non-Profit Organisation and Public Benefit Organisation which means all donations are tax-deductable. Our corporate donors also receive a beneficiary analysis certificate, a prerequisite for BBBEE certification, which shows exactly who they have helped when supporting MSF's medical work.

MSF offers complete financial transparency and accountability, so donors know exactly where their money goes every time they make a gift. In addition, companies can also choose which of MSF's four medical projects in South Africa to contribute to.
For each of these projects donors receive complete budgets, and they can even arrange to visit the projects in Khayelitsha, Mbongolwane, Johannesburg and Musina to see how their money is being spent. This is why large companies like Nedbank, Discovery Health and Lewis Stores have chosen to donate to MSF.

We also provide ways for company employees to get involved in supporting MSF's work through our Matching Gift Programme, and by supporting employees who want to arrange in-house fundraising events for MSF.

Companies can also support MSF through in-kind donations like tools, equipment, office furniture, flights, accommodation or legal or financial services. Recently, the IT company Rectron donated R50,000 worth of laptops and printers. This kind of support helps our teams enormously and we are extremely grateful for this support.

For more information, or to arrange a donation, companies and CSR/CSI managers can call Ludivine on 011 403 4440 or email ludivine.houdet@joburg.msf.org.

WHY I GIVE TO MSF

BABALWA MALI, client liaison officer, Gems Medical Aid, Pretoria

Babalwa became a regular MSF donor after meeting our Face-to-Face Fundraising team in Pretoria in 2011.
"I really want to make a difference in the world. With MSF, I know the little that I give goes a long way. R50 is a lot for some people, but for others it just a small sacrifice – like giving up one burger meal every month. So why not do it?"

Babalwa lives by the isiZulu saying, "impilo ye sizwe isesandleni zethu" – which means "people's lives are in our hands".

"Young people are the future leaders and if we don't start changing things now to make it better for the people around us, then who will? I'm willing to contribute for as long as I can and hopefully do more someday," she says.

Watch MSF teams treating malaria in Katanga Province: http://bit.ly/KWHOL/v

DRC: MASSIVE MALARIA SURGE

South Kivu: Due to the high number of severe malaria cases, the paediatric ward of MSF's Baraka hospital, is overcrowded.

Last year, the World Health Organization's annual malaria report showed significant progress in the global fight against malaria. There was a noticeable drop in malaria cases and deaths as a result of more funding and political will to buy bed nets, insecticide spray and the use of better medications that both cure malaria and stop the transmission of the disease.

But this is not the case for the DRC. Here a distressing opposite trend is unfolding. MSF, which has been working in DRC since 1981, has seen a massive increase in the number of malaria cases – including in its severest form.

Malaria has long since been one of the leading causes of illness and death in the DRC, killing 180,000 children under five annually. However, the number of people treated for malaria in MSF projects in six provinces (half of this vast country) has increased by 250 percent since 2009, with an even steeper rise in recent months.

"Since 2011, we don't see a real peak anymore – there are just always huge amounts of patients coming to us," says Christine Buesser, MSF's head of mission in North Kivu, eastern DRC. "In 2009, MSF treated around 45,000 people with malaria. So far this year, we've already treated nearly double that – about 85,000 people."

So what is driving this epidemic surge? It's hard to say, but MSF epidemiologists believe a number of factors could be at play.

In eastern DRC, ongoing insecurity and renewed fighting has prevented people from getting healthcare, and caused fresh displacement which leaves them vulnerable to contracting malaria. "At higher altitudes, there are fewer mosquitoes, so there is less malaria and people's resistance to the disease diminishes. So, if people fleeing the fighting come to lower-lying areas, they are very vulnerable to the disease. Also, people often don't dare to sleep under mosquito nets because it might slow them down when they have to flee if their village is attacked. And if they are on the run, the nets are left behind or lost on the way."

Apart from the conflict and displacement, the existing

Katanga Province: An MSF lab technician tests blood to ensure safe transfusions for malaria-related anaemia.

healthcare system in DRC suffers from a startling lack of resources, like effective antimalarial drugs and safe blood transfusions, infrastructure and trained medical personnel.

Outside the cities, healthcare is even less accessible – either due to cost, or the vast distances that patients must travel. “Some of our patients come from 10km away to our health centre, by foot, bicycle or canoe. Many are delirious with malaria,” says nurse Bilesuku Pacifique, who helps treat up to 100 malaria patients a day in MSF’s Sebele health clinic, south Kivu, eastern DRC.

The severity of the malaria cases being seen has alarmed MSF medical staff. In some hospitals where MSF works, more than 75% of admissions are severe malaria cases; some cerebral malaria which requires immediate hospitalisation and urgent blood transfusions due to malaria-induced anaemia. Most deaths are due to severe complicated malaria, with pregnant women and children being most at risk and worst affected.

In response to this growing epidemic, MSF has recently deployed additional emergency medical teams in four provinces and is boosting its regular programmes in hospitals, health centres and mobile clinics. MSF will also conduct extensive epidemiological studies in 2012 to better understand the causes of the disease spike. Due to the overwhelming scale of the needs, MSF has called on other international organisations and the DRC’s health ministry to increase their response efforts to this potential catastrophe.

Mothers at risk

Pregnant women are particularly at risk of developing severe malaria, and there is increasing evidence that malaria during pregnancy can cause life-threatening complications. For mothers-to-be these complications often mean anaemia or miscarriage. For the unborn children it could mean low birth weight or premature birth.

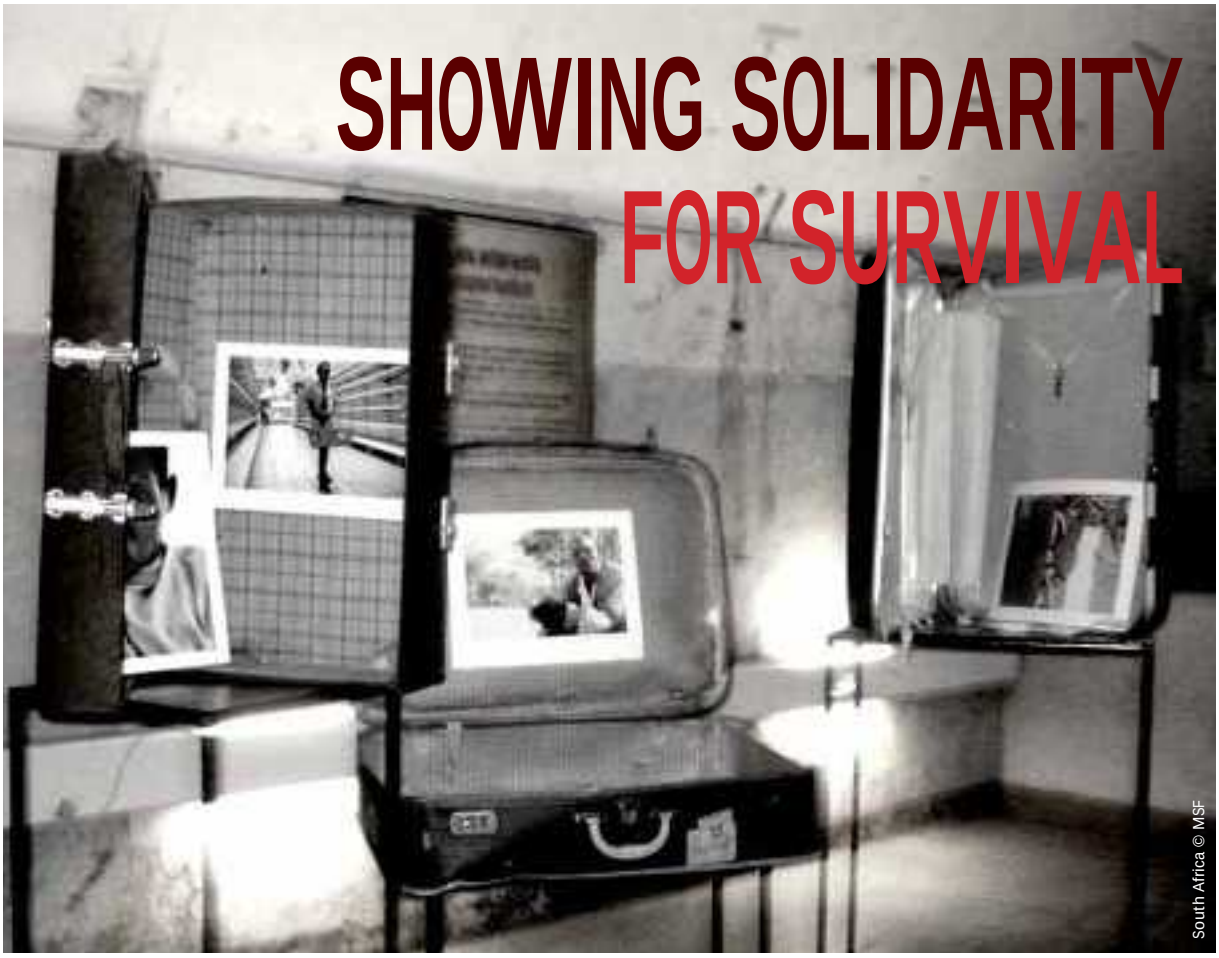
Zamukunda*, aged 20, was seven months pregnant when she developed severe malaria. The high fevers that come with malaria often provoke contractions, and Zamukunda went into early labour. She and her mother walked for two hours to get to MSF’s Kashugo clinic where she delivered her baby in the early morning hours. As both mother and child were not doing well, MSF transferred them to the MSF Mweso Hospital, north Kivu, where they were admitted to the intensive care unit.

*Not her real name.

MSF nurse Esperance with Zamukunda and her newborn baby.

Find out more: www.solidarity4survival.org.za

SHOWING SOLIDARITY FOR SURVIVAL



South Africa © MSF

In their journey towards a better life, migrants face countless challenges, including poor access to healthcare.

Every year, violence, the collapse of states and a disintegration of basic services force hundreds of thousands of people to leave their home countries to come to South Africa, and developed countries elsewhere, in the hope of surviving.

This is evidenced by the massive number of applications for asylum which South Africa's Department of Home Affairs received in 2010 – 180,000 applications, the highest figure worldwide according to the UN High Commissioner for Refugees. But the number of asylum applications presents only a partial view of the real situation. Many thousands of people cross into South Africa irregularly which means the dire situation they face and their vulnerability remains invisible for the most part.

In May this year, four years since the 2008 xenophobic violence, MSF South Africa opened the second instalment of its thought provoking Solidarity for Survival exhibition. The exhibit and campaign work seek to bring attention to the reality of thousands of people who survive displacement and migration to South Africa in the face of discrimination and being excluded from healthcare. With Solidarity for Survival, MSF South Africa wants to initiate debate and to inspire solidarity with people left most vulnerable in their struggle to access medical care and a denial of dignity, by probing the reasons for people to flee by focussing on the situation in the Democratic Republic of Congo, Somalia and Zimbabwe.

For Remy Kasanda Mukendi, aged 30, who came to South Africa from DRC in 2003, the intolerance and indifference South Africans have to the plight of vulnerable migrants is borne out of a lack of understanding: "I came here because I could not survive in DRC... We have to educate kids and tell them that foreigners are not aliens from a different planet. We come here because we think we can do better."

On a medical level MSF is also trying to raise concerns over the fact that there still exists no coherent response from both the Southern African Development Community and the South African state to deal with the healthcare needs of people on the move. The result is that their situation is ignored and they continue to suffer neglect in the face of serious public health concerns.

But despite the reality, no clear regional migration and health policies, cross-border programmes that could provide access to healthcare and continuity of care for the treatment of HIV and tuberculosis are in place.

Practically this means that very few countries in SADC use the same first line ARVs to treat HIV. The lack of accurate patient records or treatment histories makes it difficult for medical staff to provide effective treatment and appropriate care for people who move across borders as asylum seekers or migrants. This needs to change and MSF is working to define how this can be done.


South Africa © MSF


South Africa © MSF

MIGRATION: MY STORY

Zamzam Ali is a young Somali woman who travelled overland from Somalia on her own in 2009. Zamzam's mother and two younger sisters fled to Kenya last year and many of her extended family in Mogadishu have died since 2009 when she last had contact with them. Here, the 24 year-old aspiring law student shares her story. The full version is available on www.solidarity4survival.org.

What was your journey to South Africa like?

It was a very difficult thing to do. I was very afraid. For 21 days I travelled by road, because I was lucky to be able to pay for it. Many people have to walk, they stay in the bush and they end up getting lost because they don't know where to go. Some don't make it alive, some might take a year to reach South Africa.

What happens when you get sick along the way?

If you get sick you just have to carry on. You don't think about your health or eating – you just worry, thinking, thinking, thinking. You don't go to hospital because you know that staying somewhere will cost you money. You just have to keep going. You might meet people like you on the way – but they are all strangers. If you are sick and need medication they won't wait for you.

In your experience, how aware are South Africans of the situation in Somalia and why people flee to South Africa?

The South Africans I have met are very ignorant about Africa and what happens on thier continent. They act like they've never been in Africa – they seem to know more about Europe and America. The media also plays a role – there's hardly ever news about Somalia or the DRC, so people don't know what is happening.

What is your dream for the future?

Only when people have more knowledge will this situation change. South Africans must talk openly about people who come here to survive and they need to understand the reasons we come here. South Africans behave this way because they don't know their continent and what happens to people when they try to survive.

See and hear patients talking about getting healthcare in conflict-ridden Afghanistan:
http://bit.ly/KpEqk0

LETTER FROM THE FIELD

Adeline Oliver: Aged 61, from Johannesburg

Position: Operating Theatre Nurse

Location: MSF-supported hospital in Lashkargah, Helmand province, Afghanistan.

When I arrived in Helmand province in December 2011 it was extremely cold with frosty mornings. It's spring now, which is beautiful, but some days are unbearably hot. I've been working for nearly six months, supervising nearly 20 nurses and 20 cleaning staff in the operating theatre, sterilisation department, intensive care unit and female in-patient department of Boost Hospital, which sits on the outskirts of Lashkargah.

My relationship with the Afghan staff I supervise is good. But the language barrier is still a challenge – particularly in the female inpatient department. Only the supervisor speaks very minimal English, so it can be difficult to get messages through. It is hard to find qualified, English-speaking staff, especially in an area like Helmand which is heavily affected by years of war. In the sterilisation team, most of the staff I oversee are illiterate, but they are very committed and a pleasure to work with. Together we have found creative ways of communicating by using drawings to get the point across.

In the operating theatre we see a lot of general trauma cases – mostly road traffic accidents. Surprisingly, we see many children under the age of one with bladder stones requiring surgery – the youngest was only four months old! We suspect this might be due to water pollution. In winter, when I arrived, we saw many women and children with burn wounds from exploding oil heaters.

At least once a week we receive someone in a coma, the cause of which has really baffled me. At first we were not sure if the comas were drug-related, maybe malaria, or something completely different. One patient I really made a connection with was a 30-year old woman who came to us in one of these "unknown comas". We managed to discover she was ill with hepatitis, and cured her. She woke up after five days in a coma. When I saw her later, she was so happy. She kept thanking us for saving her life. It was amazing to see the gratitude for MSF's work.

What makes my job hard is to see patients dying because they only seek medical help very late. It could be because transport is difficult due to insecurity, or being unable to pay for the ride to the hospital. Sometimes they're simply not aware of how serious their medical problems are. I sometimes feel so helpless watching people die from diseases that could have been prevented with earlier medical intervention.

Lashkargah, and Helmand as a whole, is an impoverished area where people have very little. MSF's services – drugs, medical care – are completely free. We're trying to make people understand that the poor quality drugs they get on the local market are both expensive and often toxic.

Helmand is obviously not a secure area, and has seen a lot of fighting in recent years. I've heard a few bomb blasts, but it hasn't affected our work. It's as safe as it can be – as long as you follow MSF's strict security rules, which means we only travel to and from the hospital, never in the city. I haven't found the restrictions too difficult – we have a big team and everyone is supportive.

This is my first mission with MSF. But being retired from my nursing job in South Africa made it easier. My years of training and nursing experience in South Africa have been invaluable in this situation.

Find out more about the struggles of a South Sudanese mother to vaccinate her baby: http://bit.ly/KNI9og

BETTER VACCINES: GETTING THE RIGHT SHOT

Get the basics right. Design vaccines for developing countries to save more lives.

A staggering 19.3 million children born each year are left vulnerable to contracting, or succumbing to preventable diseases because they are still missed in vaccination programmes in developing countries. Despite improvements in countries' routine inoculations very little is done to optimise existing immunisation tools and strategies, while introduction of new vaccines are championed most.

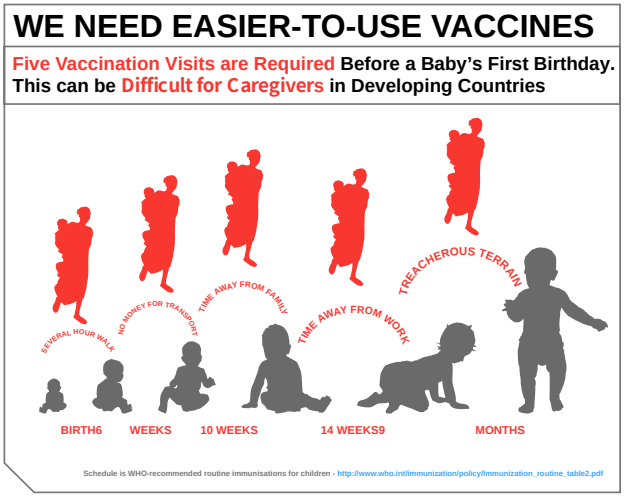
"Focussing on the newest vaccines without boosting existing systems is not a strategy that will benefit the most children: we can't just keep piling on new vaccines and fail to get the basics right," Dr. Estrella Lasry of MSF explains.

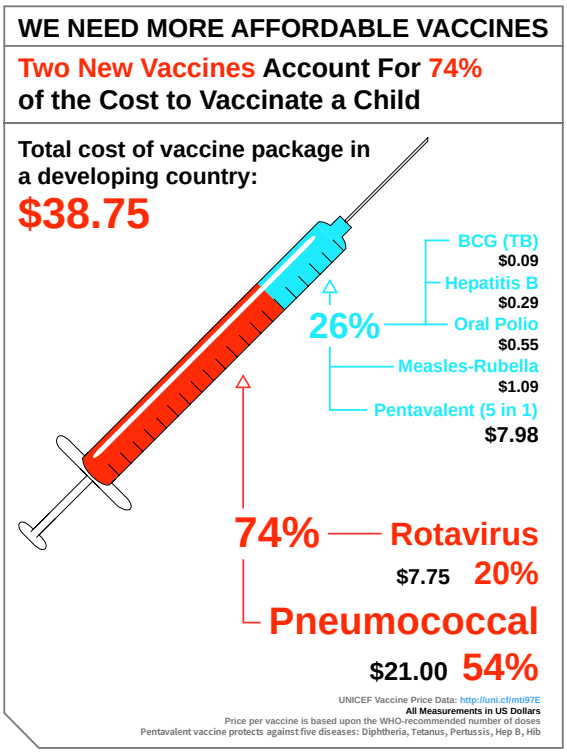
Each year, MSF teams vaccinate over 10 million people, primarily as outbreak response to diseases such as measles, meningitis, diphtheria, pertussis and yellow fever. Based on field experience, MSF feels that without better adapting vaccines to developing country needs and making them more affordable, the battle to close the immunisation gaps will be lost.

In order to reach the millions of children currently unreached by immunisation, we need:

- Heat-stable vaccines: Most vaccines must be kept at temperatures between 2-8°C. This is impractical in hot countries with limited refrigeration capacity and unreliable electricity supply. Having to keep vaccines cold increases logistical complexity and costs.
- Vaccine versions which don't just have to be injected: Vaccine injections require trained health workers who are in short supply in remote places, making it difficult and costly to extend inoculation reach. Vaccines that are inhalable; given orally, administered via a patch on the skin; or through a 'microneedle' (a simple pre-filled single-dose vaccine), enable community health workers to get the job done.
- Developing country epidemiology should guide vaccine design: Nearly all vaccines are developed initially for wealthy markets, creating a bias toward disease strains in wealthy countries rather than where the biggest needs are.
- Vaccines need to be more affordable: Price prevents greater access to vaccines in developing countries. The prices countries pay can also vary dramatically: South Africa has been paying a sky-high US$26 per dose for Pfizer's pneumococcal vaccine, much more than the US$16.34 countries in the Pan American Health Organization pay.

To learn more, read MSF's report 'The Right Shot: Extending the reach of affordable and adapted vaccines': http://bit.ly/JCe00h





Learn how an MSF-run outpatient feeding centre works in northern Chad:
http://bit.ly/KeHrmX

HUNGER IN THE SAHEL

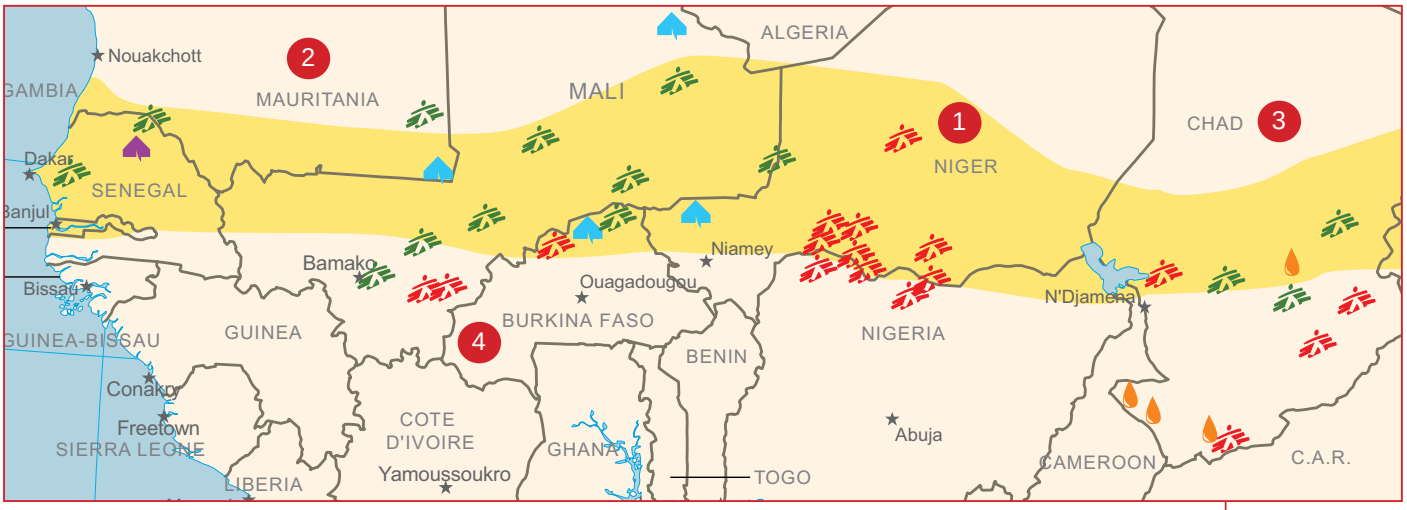
A nutritional crisis is growing in the Sahel region of West Africa, a huge area that includes eight countries: Burkina Faso, Chad, Cameroon, Niger, Nigeria, Mali, Mauritania and Senegal.

A dangerous combination of conflict, political instability, below normal harvests and economic crises will significantly worsen the annual hunger season that affects these arid parts where hundreds of thousands of people are at risk.

MSF, which has nutrition programmes in most of these countries, is responding with new approaches to meet the impact of malnutrition by implementing preventative nutrition, new vaccination programmes and community distribution of food supplements.

NIGER: Djamila, aged 2, arrived at MSF's Intensive Therapeutic Feeding Centre suffering the effects of severe kwashiorkor (protein deficiency). Eleven days later, she is in a much more stable condition. In 2011, MSF treated over 104,000 children with malnutrition in Niger alone.

CHAD: Malnutrition and infection are a deadly combination: lack of nutrition inhibits the immune system, and infectious disease worsens malnutrition. Meningitis – an inflammation of brain membranes – is particularly prevalent in the Sahel. A severe outbreak of meningitis A hit Chad in February 2012. MSF vaccinated 110,000 people with a new MenAfriVac vaccine that lasts for 10 years instead of 2 to 3 years.



NIGER: An underweight baby is weighed to determine his level of malnutrition in an MSF-supported integrated health centre in Maradi region. Niger experiences high rates of malnutrition even under normal circumstances, but UN figures show an unprecedented 330,000 Nigerien children will have to be treated for severe malnutrition this year.

MSF SAHEL LEGEND:

- Current Projects
- New Interventions
- Mali Refugee/ IDP Assessment
- Mali Refugee/ IDP Intervention
- Meningitis Vaccination Campaign

MAURITANIA: Violent clashes in northern Mali in January drove nearly 55,000 Malians into neighbouring Mauritania. Most refugees gathered in Mbera camp, 3 km from the Mali border. MSF provides primary and maternal healthcare, as well as desperately needed water supplies.

BURKINA FASO: MSF has worked in Titao, northern Loroum province since 2007, supporting over 55,000 acutely malnourished children in 11 nutritional centers like this one. Simple tools, such as these, are used to feed malnourished children back to health with specially formulated milk. MSF expanded its nutrition services in Titao to a broader range of pediatric services in early 2012.

LIFTING THE LID ON HUMANITARIAN NEGOTIATIONS

New book gives insight into how MSF gains access to war zones

Daily Maverick's Greg Nicholson recently reviewed MSF's new book *Humanitarian Negotiations Revealed,* having interviewed two of the book's contributors, Michiel Hofman and Rony Brauman in Johannesburg. The book lays bare the various myths surrounding humanitarian aid, and explores the compromises and justifications made in contexts as diverse as Afghanistan, Sri Lanka, France and South Africa.

This is an edited version of Nicholson's article – read the full version here: http://bit.ly/KcZnyl

After a long history of operating in Afghanistan, MSF announced its withdrawal in 2004. Five of its workers had been assassinated in Badghis province and the authorities had made no attempt to arrest the perpetrators.

"The principle championed by MSF – that civilian professionals providing medical help to the suffering will be granted safe passage – is now part of our nostalgic past," wrote academic Cheryl Bernard in The Wall Street Journal. Michiel Hofman, however, believes the reality is more complex. Head of the team who took MSF back to Afghanistan in 2009, Hofman co-authored a chapter of the book – and says that while the assassinations were "terrible enough", they alone were not the reason for the withdrawal.

"MSF is an organisation that knows it is working in conflict situations and instils in its employees and volunteers that if you sign up, you have to accept that you are taking personal responsibility for an unusual level of risk," he says.

For Hofman, the key has always been negotiations above obligations. He believes it is an MSF practitioner's role to find the overlapping objectives between humanitarians, politicians, military and warlords to gain safe access, and work from there.

"There can be a multitude of things that the various sides are looking for. The most common one is: if you're a military the only way to control the population is to also provide some basic services to the population," says Hofman. "What people need is food, water, shelter and medical care. We provide the product of medical care."

Humanitarian Negotiations Revealed provides an insight to situations where "everything is open to negotiation". As long as the compromises "reduce the number of deaths, the suffering and the frequency of incapacitating handicaps within groups of people who are usually poorly served by public health systems," reads the introduction.

But as actors in conflict zones who enter into agreements with warlords, rebels, aggressors and governments, MSF's compromises are a gamble and subject to criticism. In Sri Lanka it was suspected of supporting the Tamil Tigers, and so agreed with the government not to speak out on what it saw. In Somalia, it was required to pay taxes to Al Shabaab militants.

"We negotiate on many things... because everything is subject to negotiation," says Rony Brauman, a medical doctor and MSF veteran – noting that the only area in which there will be no negotiation is torture. The book reveals MSF's dedicated attempts to offer medical services to those in need and, it appears, the organisation does not stray far from this essential goal.

By staying within its limits, MSF is able to access patients in some of the most dangerous conflict and disaster zones around the world. But for those who negotiate the organisation's way in, it comes at a personal cost. During the recent famine in Somalia, Hofman set up the emergency response mission in Mogadishu. Two of his colleagues were shot in the following months.

Hofman hopes that laying bare the complex reality of MSF's work will help the aid industry become more transparent. "Wars are nasty, dirty, messy places. Anybody that enters into that arena will become part of the messiness. Everybody that engages will make compromises, take risks and continuously struggle with dilemmas that are very uncomfortable," says Hofman.

"In the end, transparency, to be honest about it, is still the best weapon to be able to get access."

MSF South Africa is launching Humanitarian Negotiations Revealed later in 2012. To find out more email borrie.lagrange@joburg.msf.org or call 011 403 4441.

BACK FROM THE FIELD - SEDI MBELANI

Nurse, Niger

Sedi Mbelani, aged 31, originates from Congo-Brazzaville, but currently lives in South Africa. She studied nursing in Brazzavile, joining MSF shortly after completing her practical training. Sedi came to South Africa in 2003, where she continued her nursing studies working variously with orphaned children and handicapped adults. During the xenophobic violence in South Africa she worked with MSF again, providing medical care for people living in camps for the displaced. Sedi recently returned from a nine-month contract as a nurse in Niger.

Niger ©MSF

What were you doing with MSF in Niger?

I was working as a nurse supervisor, coordinating up to 70 nurses and 24 nutrition assistants on MSF's project in Madaoua in southern Niger.

The project focusses on mother-and-child healthcare – ensuring free healthcare to new mothers or pregnant women, and also to children under five living in Madaoua and the surrounding districts. MSF runs an 84-bed nutrition centre, a 56-bed paediatric hospital, and a 12-bed unit for babies born prematurely. There are also six mobile clinics which reach out to surrounding villages, a huge pharmacy and an information, education and communication team that provide health education.

Nutritional crises are a chronic problem in Niger. There was a severe nutritional crisis in 2005 – 2006 and another, less severe one in 2010.

Did you see high levels of malnutrition during your time there, as reported recently?

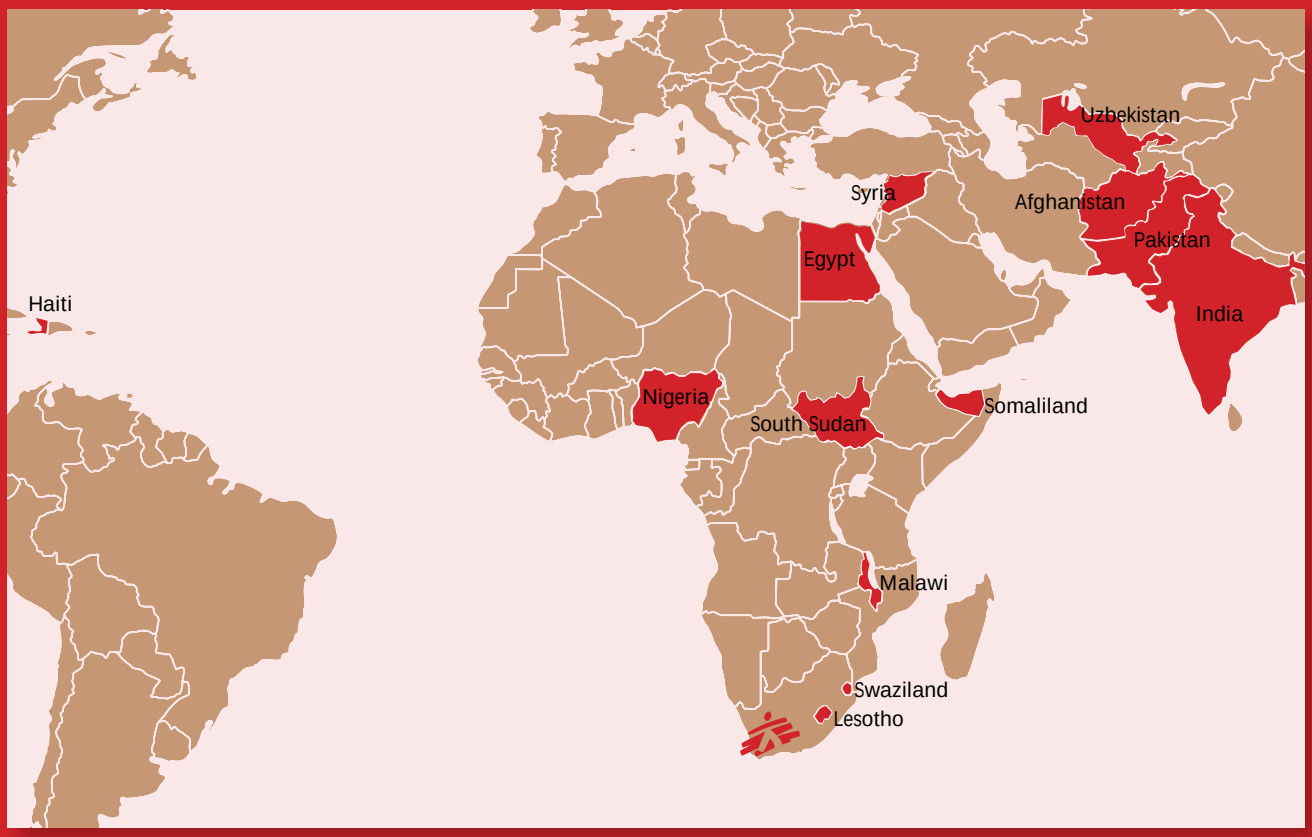
MSF has worked in Niger since 1985, but increased its nutrition activities in northern Niger in 2006 after a combination of drought, locust swarms, high food prices and severe poverty pushed people over the edge. This region generally sees a seasonal increase in malnutrition each year, but this year we are seeing higher numbers of children suffering from malnutrition in Madaoua. We know that we are reaching a greater number of villages so we are seeing more patients than before. They are also suffering from other diseases too.

What were the most common diseases that affect children in Madaoua?

More than anything, we treated children with malaria – which accounted for 32% of our patients in 2011 – and respiratory tract infections which represented about 27% of our caseload. Malaria also causes secondary complications, like clinical anaemia. During my time there around 12% of children we saw were suffering from severe, acute malnutrition. The majority of children we treated were also moderately malnourished so they were able to recover reasonably quickly after receiving nutritional support services that prevented their conditions from worsening rapidly.

Did your time in Niger motivate you in any way?

The Madaoua project had a big vaccination component, in particular for measles, which is very prevalent in this part of Africa due to insufficient or ineffective vaccination programme coverage when children are young. At the moment I'm completing an MSF-designed online course about measles and how to manage outbreaks, because I'd like to work with MSF on a vaccination campaign at some point in the future.



MSF SOUTH AFRICA: OUR RECRUITS IN THE FIELD IN 2012

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Bob Bushiri - HIV/TB Doctor – Malawi
Chenai Sekai – Nurse – Uzbekistan
Dmitry Stareverov – Anaesthetist – Somaliland
Everlyn Wachira – Nurse – Egypt
Garret Barnwell – Liason Officer – Syria/Lebanon
Joyce Njenga – Midwife – Afghanistan
Kokola Kabengele - HIV/TB doctor – Malawi
Marilize Ackermann – Administration & Finance – India
Mohammed Golo – Nurse – Afghanistan
Natalie Valhakis – Medical Doctor – Lesotho
Patricia Nyoni – Nurse – Swaziland
Priviledge Ruredzo – Finance – South Sudan
Tinnie Gils – Pharmacist – Lesotho
Tracy Lydon – Water & Sanitation Engineer – Haiti
Vanessa Naidoo – Anaesthetist – Afghanistan & Pakistan
Virginia Kinyajui – Nurse – Nigeria

MSF South Africa thanks all our field workers for their enormous contribution to MSF's operations worldwide. MSF is always looking for medical professionals, in particular doctors, surgeons, nurses, midwives, epidemiologists and laboratory scientists.

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